3. The Division then ranks the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 114.1 CMR 36.07(2)(b)2.

4. The Division then determines the 75th percentile of the ratios determined in 114.1 CMR 36.07(2)(b)2.

5. Hospitals who meet or exceed the 75th percentile qualify for a High Public Payer Hospital Adjustment. The Division multiplies each qualifying hospital's allowable free care charges by the hospital's most recent cost to charge ratio, as calculated pursuant to 114.6 CMR 11.04 to determine allowable free care costs.

6. The Division then determines the sum of the amounts determined in 114.1 CMR 36.07(2)(b)5. for all hospitals that qualify for a High Public Payer adjustment.

7. Each eligible hospital's High Public Payer Hospitals adjustment is equal the amount allocated in 114.1 CMR 36.07(2)(b)1. multiplied by the amount determined in 114.1 CMR 36.07(2)(b)5. and divided by the amount determined in 114.1 CMR 36.07(2)(b)6.

(c) Calculation of Additional Adjustment for High Public Payer Hospitals with Adolescent Psychiatry Units.

1. Hospitals qualifying under 114.1 CMR 36.07(2)(b)5 that have a minimum licensed capacity of fourteen (14) adolescent psychiatry beds, and have entered into a contract with the Division of Medical Assistance's behavioral health contractor in calendar year 1999 for the provision of adolescent psychiatric services, shall be eligible for an additional disproportionate share adjustment.

2. The availability and total amount of funds allocated for this adjustment are subject to specific legislative appropriation and federal financial participation. This adjustment will be reasonably related to the costs and services provided to patients eligible for Medical Assistance under Title XIX, or to low income patients.

(3) Basic Federally - Mandated Disproportionate Share Adjustment

(a). The Division determines a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Division uses the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

1. The Division uses free care charge data from the prior year filing of the Division's uncompensated care reporting form..

2. The prior year RSC-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient charges, and the state and/or local cash subsidy.

(b). The Division calculates a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Division determines such threshold as follows:

1. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This is determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

2. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

3. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.

4. The Division then calculates each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3., then the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(c). The Division then calculates each hospital's low-income utilization rate as follows:

1. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

2. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

3. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.07(3)(c)1. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.07(3)(c)2. If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

(d). Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement is calculated as follows:

1. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.07(3), the Division divides the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)4. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

2. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division divides the hospital's low-income utilization rate by 25%. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

3. The Division then determines, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.07(3)(d)1. and 114.1 CMR 36.07(3)(d)2.

4. The Division then calculates a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.07(3)(e). by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.07(3)(d)3.

5. The Division then multiplies the minimum payment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.07(3)(d)1. and 2. The product of such multiplication is the payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

(e) The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement is $200,000 per year. These amounts are paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.07(3)(d)5.

(4) Disproportionate Share Adjustment for Safety Net Providers. The Division determines a disproportionate share safety net adjustment factor for all eligible hospitals, using the data and methodology described in 114.1 CMR 36.07(4).

(a). Data Sources. The Division uses free care charge data from the prior year's filing of the Division's UC-9x report and total charges from the DHCFP-403. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

(b) Eligibility of Disproportionate Share Hospitals for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is a payment for hospitals which meet the following criteria:

1. is a public hospital or a public service hospital as defined in 114.1 CMR 36.02.;

2. has a volume of Medicaid and free care charges in FY93, or for any new hospital, in the base year as determined by the Division of Health Care Finance and Policy which is at least 15% of its total charges;

3. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients;

4. has completed an agreement with or is the specified beneficiary of an agreement with the Division of Medical Assistance for intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for the disproportionate share adjustment for safety net providers;

5. is the subject of an appropriation requiring an intergovernmental funds transfer;

6. the public entity obligated to make an intergovernmental funds transfer does in fact meet its obligation in accordance with the agreement referenced at 114.1 CMR 36.07(4)(b)4. above.

(c) Payment to Hospitals under the Adjustment for Safety Net Providers. The Division calculates an adjustment for hospitals which are eligible for the safety net provider

adjustment, pursuant to 114.1 CMR 36.07(4)(b). This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and equals the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. The disproportionate share adjustment for safety net providers is not in effect for any rate year in which Federal Financial Participation (FFP) under Title XIX is unavailable for this payment. The amount payable is also subject to the amount of FFP which continues to be available for this payment.

(d). If a public entity has not met its obligation to make an intergovernmental funds transfer, the Division of Medical Assistance shall have the right to recoup any safety net disproportionate share payment amount which is conditioned on the receipt by the Commonwealth of said intergovernmental funds transfer.

(5) Uncompensated Care Disproportionate Share Adjustment Hospitals eligible for this adjustment are those that report "free care costs," as defined by 114.6 CMR 11.00 and who are participating in the free care pool administered by the Division pursuant to M.G.L. c. 118G. The payment amounts for eligible hospitals are determined by the Division in accordance with its regulations at 114.6 CMR 11.00. These payments are made to eligible hospitals in accordance with the Division's regulations and the interagency service agreement (ISA) between the Division of Medical Assistance and the Division of Health Care Finance and Policy. Eligible hospitals receive these payments on a periodic basis during the term of their Medicaid contract with the Division.

(6) Public Health Substance Abuse Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000, as limited in DPH's ISA with the Division of Medical Assistance (DMA). The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 and DPH's ISA with DMA.

(7) Disproportionate Share Adjustment for Non-profit Acute Care Teaching Hospitals affiliated with a Commonwealth-Owned University Medical School. The Division will determine for FY98 and succeeding years a disproportionate share adjustment for the acute care teaching hospitals that have an affiliation with university medical schools owned by the Commonwealth of Massachusetts.

(a). Eligibility. In order to be eligible for this adjustment, the following conditions must be met:

1. the hospital must enter into an agreement with the state-owned university medical school to purchase medical education, clinical support, and clinical activities from the medical school;
2. the hospital must have a common mission as established by state law, with the state owned university medical school, to train physicians, nurses, and allied health professionals according to high professional and ethical standards and to provide quality health care services;
3. the hospital must have completed an agreement with or is the specified beneficiary of an agreement with the Division of Medical Assistance concerning intergovernmental transfer of funds, as defined in federal regulations governing state

financial participation as a condition of federal reimbursement, to the Medicaid program for this disproportionate share adjustment;

4. the hospital must be the subject of an appropriation requiring a public entity to make an intergovernmental funds transfer; and.

5. The public entity obligated to make an intergovernmental funds transfer does in fact meet its obligation in accordance with the agreement referenced in 114.1 CMR 36.07(7)(a)3.

(b). Payment amount. The Division calculates an adjustment for eligible hospitals. This adjustment will be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and will equal the amount of funds specified in an agreement between the Division of Medical Assistance and the relevant governmental unit. This disproportionate share adjustment is subject to the availability of federal financial participation.

(8) Disproportionate Share Adjustments for Pediatric Specialty Hospitals or Units. The Division will determine for FY00 and succeeding years a disproportionate share adjustment for Pediatric Specialty Hospitals or Units.

(a) Eligibility. In order to be eligible for this adjustment, the hospital must meet the definition of a Pediatric Specialty Hospital or Unit as defined in 114.1 CMR 36.02. In addition, the hospital must have a signed contract with the Division of Medical Assistance and be reimbursed under 130 CMR 415.406 for the period that such adjustment is in effect.

(b) Methodology. The Division will calculate an adjustment as follows:

1. For each eligible hospital, the Division will calculate the ratio of MassHealth pediatric days to the total MassHealth pediatric days for all eligible hospitals.
2. The Division will multiply the ratio calculated in 114.3 CMR 36.07(8)(b)1 by the total allocation cited in 114.3 CMR 36.07(8)(c) to determine the payment amount for each hospital.
3. The disproportionate share adjustment will reimburse only those costs that have not otherwise been reimbursed and will be paid subject to the availability of federal financial participation.

(c) Payment Amount. The total amount of funds allocated for payment to hospitals will be the amount appropriated for such. These amounts are determined pursuant to 114.1 CMR 36.07(8)(b). Payments are made by the Division of Medical Assistance and distributed among eligible hospitals determined pursuant to 114.1 CMR 36.07(8)(a).

36.08: Medicaid rates of payment for Emergency Services at Hospitals that Do Not Contract with the Division of Medical Assistance

(1) Overview: 36.08 establishes rates of payment to acute care hospitals who have not signed a contract with the Division of Medical Assistance. Rates of payment for all emergency services and continuing emergency care provided in an acute hospital to medical assistance program recipients, including examination or treatment for an emergency medical condition or active labor in women or any other care rendered to the extent required by 42 USC 1395 (dd), are as follows:

(2) Payment for emergency inpatient admissions is made using the transfer *per diem* rate of payment, established according to the methodology set forth in 114.1 CMR 36.05(4), up to the

114.6 CMR 11.00: ADMINISTRATION OF THE UNCOMPENSATED CARE POOL

Section

11.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.6 CMR 11.00 governs the procedures effective October 1, 2000 for administering the Uncompensated Care Pool, including payments to acute hospitals and community health centers and payments from acute hospitals and surcharge payers.

(2) Authority. 114.6 CMR 11.00 is adopted pursuant to M.G.L. c. 118G.

11.02: Definitions

Meaning of Terms: As used in 114.6 CMR 11.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 114.6 CMR 11.00 are capitalized.

Allowable Free Care Costs. A Hospital's total allowable Free Care Charges multiplied by its Cost to Charge Ratio.

Ambulatory Surgical Center. Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring Hospitalization and meets the Health Care Financing Administration requirements for participation in the Medicare program.

Ambulatory Surgical Center Services. Services described for purposes of the Medicare program pursuant to 42 USC §1395k(a)(2)(F)(I). These services include only facility services and do not include physician fees.

Charge. The uniform price for a specific service charged by a Hospital or Community Health Center.

Commissioner. The Commissioner of the Division of Health Care Finance and Policy or designee.

Community Health Center. A clinic which provides comprehensive ambulatory services and which:

(a) is licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51;
(b) meets the qualifications for certification (or provisional certification) by the Division of Medical Assistance and enters into a provider agreement pursuant to 130 CMR 405.000;
(c) operates in conformance with the requirements of 42 U.S.C. § 254(c); and
(d) files cost reports as requested by the Division.

Compliance Liability Revenues. Amounts paid by Hospitals into the Uncompensated Care Trust Fund pursuant to St. 1991, c 495, § 56.

Cost to Charge Ratio. A percentage used to reduce Uncompensated Care Charges to costs, calculated pursuant to 114.6 CMR 11.04(4).

Disproportionate Share Hospital. A Hospital which serves a disproportionate share of low income patients and which meets the criteria set forth in 114.1 CMR 36.04.

11.02: continued

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G or its designated agent.

Emergency Bad Debt. The amount of uncollectible debt for emergency services which meets the criteria set forth in 114.6 CMR 10.00.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the following calendar year.

Free Care. Unpaid Hospital or Community Health Center Charges for medically necessary services which are eligible for reimbursement from the Uncompensated Care Pool pursuant to the criteria set forth in 114.6 CMR 10.00.

Governmental Unit. The commonwealth, any department, agency board, or commission of the Commonwealth, and any political subdivision of the commonwealth.

Gross Patient Service Revenue. The total dollar amount of a Hospital's Charges for services rendered in a Fiscal Year.

Guarantor. A person or group of persons who assumes the responsibility of payment for all or part of a Hospital's or Community Health Center's Charge for services.

Hospital. An acute Hospital licensed under M.G.L. c. 111, § 51 and the teaching Hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

Hospital Services. Services listed on a Hospital's license by the Department of Public Health.

Indirect Payment. A payment made by an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I to a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, which then forward the payment to member Hospitals or Ambulatory Surgical Centers; or a payment made to an individual to reimburse him or her for a payment made to a Hospital or Ambulatory Surgical Center.

Individual Medical Visit. A face-to-face meeting between a recipient and a physician, physician assistant, nurse practitioner, or registered nurse within the Community Health Center setting, for purposes of examination, diagnosis, or treatment.

Individual Payer. A patient or Guarantor who pays his or her own Hospital or Ambulatory Surgical Center bill and is not eligible for reimbursement from an insurer or other source.

Institutional Payer. A Surcharge Payer that is an entity other than an Individual Payer.

Medicare Program. The medical insurance program established by Title XVIII of the Social Security Act.

Patient. An individual who is receiving or has received medically necessary services at a Hospital or Community Health Center.

Payment. A check, draft or other paper instrument, an electronic fund transfer, or any order, instruction, or authorization to a financial institution to debit one account and credit another.

Pool. The Uncompensated Care Pool established pursuant to M.G.L. c.118G, § 18.

Private Sector Charges. Gross Patient Service Revenues attributable to all patients less Gross Patient Service Revenue attributable to Titles XVIII and XIX, other publicly aided patients, Free Care and bad debt.

11.02: continued

Public Service Hospital. Any public Hospital or any acute Hospital operating pursuant to St. 1995, c. 147, which has a private sector payer mix that constitutes less than 25% of its Gross Patient Service Revenue (GPSR) and where Uncompensated Care comprises more than 20% of its GPSR.

Publicly Aided Patient. A person who receives Hospital or Community Health Center care and services for which a Governmental Unit is liable in whole or in part under a statutory program.

Registered Payer List. A list of Institutional Payers as defined in 114.6 CMR 11.05(3)(b).

Shortfall Amount. The positive difference between the sum of Allowable Free Care Costs for all Hospitals and the revenue available for distribution to Hospitals as set forth in 114.6 CMR 11.04(3)(d).

Sole Community Hospital. Any acute Hospital classified as a Sole Community Hospital by the U.S. Health Care Financing Administration's Medicare regulations, or any Hospital which demonstrates to the Division's satisfaction that it is located more than 25 miles from other acute Hospitals in the Commonwealth and that it provides services for at least 60% of its primary service area.

Specialty Hospital. An acute Hospital qualifying as exempt from the Medicare prospective payment system regulations or any acute Hospital which limits its admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to children or patients under obstetrical care.

Surcharge Payer. An individual or entity that:

(a) makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; and

(b) meets the criteria set forth in 114.6 CMR 11.05(1)(a).

Surcharge Percentage. The percentage assessed on certain payments to Hospitals and Ambulatory Surgical Centers determined pursuant to 114.6 CMR 11.05(2).

Third Party Administrator. An entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee. A Third Party Administrator may provide client services for a self-insured plan or an insurance carrier's plan. Third Party Administrators will be deemed to use a client plan's funds to pay for health care services whether the Third Party Administrator pays providers with funds from a client plan, with funds advanced by the Third Party Administrator subject to reimbursement by the client plan, or with funds deposited with the Third Party Administrator by a client plan.

Uncompensated Care. The sum of reported net Free Care and net Emergency Bad Debt.

11.03: Reporting Requirements

(1) General. Each Hospital, Community Health Center, Surcharge Payer and Ambulatory Surgical Center shall file or make available information which is required or which the Division deems reasonably necessary for implementation of 114.6 CMR 11.00.

(a) Due Date. For any filing requirement without a specified time for filing, the submission is due 15 days from the date of the request of the Division. The Division may, for cause, extend the filing date. Any request for an extension must be made in writing and submitted to the Division in advance of the filing date.

(b) Patient Level Data. Hospitals and Community Health Centers must make Uncompensated Care Pool patient level data available to the Division upon request. These patient level data include but are not limited to cost data, patient diagnoses and types of uncompensated services provided, patient demographics, write-off amounts, unique patient identifiers, and other such data that enable the Division to conduct analyses, verify eligibility, and calculate settlements on a case-by-case basis.

11.03: continued

(c) Audit. The Division may audit data submitted under 114.6 CMR 11.03 to ensure accuracy. The Division may adjust reported Free Care to reflect audit findings.

(2) Hospitals.

(a) UC Form. Each Hospital must submit a DHCFP UC-Form monthly within 45 days after the end of the reporting period.

(b) Unmatched Payer Report. Each Hospital must submit an Unmatched Payer Report to the Division every four months, in accordance with a schedule specified by the Division. The Hospital must report the total amount of payments for services received from each Institutional Payer which does not appear on the Registered Payer List. The hospital must report these data in an electronic format specified by the Division.

(c) Quarterly Report for Private Sector Payments. Each Hospital must report total payments made by the largest Institutional Surcharge Payers. The Division will specify: the Institutional payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Division may modify the reporting requirements from time to time by administrative bulletin.

(d) Electronic Data Submission. Each Hospital must submit free care application and claims data to the Division in accordance with the requirements of 114.6 CMR 11.03(6).

(e) Penalties. The Division may deny reimbursement for Free Care to any Hospital which fails to comply with the reporting requirements of 114.6 CMR 11.00 until such Hospital complies with the requirements. The Division will notify such Hospital of its intention to withhold reimbursement.

(3) Community Health Centers.

(a) Free Care Payment Voucher. Each Community Health Center must submit a monthly payment voucher detailing the center's Individual Medical Visits that qualify for Free Care within 45 days after the last day of the designated reporting period.

(b) Each Community Health Center must, upon request, provide the Division with patient account records and related reports as set forth in 114.6 CMR 11.03(1)(b).

(c) Electronic Data Submission. Each Community Health Center must submit free care application and claims data to the Division in accordance with the requirements of 114.6 CMR 11.03(6).

(d) Penalties. The Division may deny reimbursement for Free Care to any Community Health Center which fails to comply with the reporting requirements of 114.6 CMR 11.00 until such Community Health Center complies with the requirements. The Division will notify Community Health Centers of its intention to withhold reimbursement.

(4) Surcharge Payers.

(a) Monthly Surcharge Payment Report. The Division may require certain Institutional Payers to submit reports of payments to Hospitals and Ambulatory Surgical Centers.

(b) Third Party Administrators.

1. A Third Party Administrator Surcharge Payer that makes payments to Hospitals and Ambulatory Surgical Centers on behalf of one or more insurance carriers must file an annual report with the Division. The report shall include the name of each insurance carrier for which it make surcharge payments. The report shall be in an electronic format specified by the Division.

2. Third Party Administrators must submit annual reports by July 1 of each year for the time period defined by the Division.

(c) Penalties. Any Surcharge Payer that fails to file data, statistics, schedules, or other information pursuant to 114.6 CMR 11.03 or which falsifies same, shall be subject to a civil penalty of not more than $5000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General shall bring any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 114.6 CMR 11.00.

11.03: continued

(5) Ambulatory Surgical Centers.

(a) Unmatched Payer Report. Each Ambulatory Surgical Center must submit an unmatched payer report to the Division every four months, in accordance with a schedule specified by the Division. The Ambulatory Surgical Center must report the total amount of payments for services received from each Institutional Surcharge Payer which does not appear on the Registered Payer List.

(b) Quarterly Report for Private Sector Payments. Each Ambulatory Surgical Center must report total payments made by the largest Institutional Surcharge Payers. The Division will specify the Institutional Payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Division may modify the reporting requirements from time to time by administrative bulletin.

(c) Penalties. An Ambulatory Surgical Center that knowingly fails to file with the Division any data required by 114.6 CMR 11.03 or knowingly falsifies the same shall be subject to a $500.00 fine.

(6) Electronic Data Submission Requirements.

(a) Free Care Application Data.

1. Hospitals and Community Health Centers must use electronic free care application software provided by the Division to collect free care application data and must maintain such data in a database as specified by the Division. A provider may continue to use paper applications but must insure that all applications, whether approved or denied, are loaded into its database.

2. Each Provider must ensure that its hardware and technical infrastructure supports the Division's electronic data collection process.

3. Each Provider must submit application data at least monthly, in accordance with a schedule to be determined by the Division.

(b) Free Care Claims Data.

1. Hospitals and Community Health Centers must submit medical claims information for all services for which payment is claimed from the Uncompensated Care Pool. Providers must complete and submit claims, and resubmit failed claims, in accordance with Division specifications.

2. Hospitals will continue to submit UC Forms, and Community Health Centers will continue to submit PV Forms, for payment from the Uncompensated Care Pool.

(c) Other.

1. The Division may revise the data specifications, the data collection scheduled, or other administrative requirements from time to time by administrative bulletin.

2. Providers must continue to meet all screening and documentation requirements of 114.6 CMR 10.00

3. Providers must maintain, at a minimum, copies of the signature page of the free care application and all eligibility documentation required by 114.6 CMR 10.00.

11.04: Payments From and To Hospitals

(1) Revenue Available for Payments to Hospitals for Free Care.

(a) Available revenue for each Fiscal Year consists of:

1. revenues produced by Hospital assessments under 114.6 CMR 11.04
2. revenues produced by the Uncompensated Care Pool Surcharge under 114.6 CMR 11.05,
3. supplemental funding consisting of designated Compliance Liability Revenues; and
4. state appropriations of federal financial participation funds and any other available appropriations

(b) Available revenue is reduced by:

1. payments to Community Health Centers under 114.6 CMR 11.06;
2. amounts withheld as reserves for contingencies;
3. expenses for administration of the Pool authorized by M.G.L. c. 118G;
4. demonstration projects authorized under M.G.L. c. 118G, §18(d)
5. expenses for managed care contracts or interagency service agreements to provide services to individuals eligible for free care as authorized by M.G.L. c. 118G, § 18(j).

11.04: continued

(c) Supplemental funding is the primary source of funding for Free Care to Community Health Centers. If this funding source is insufficient, then revenue provided through other sources will be made available. Any supplemental funding remaining after payments to Community Health Centers will be made available for other Pool purposes.

(d) For the purpose of demonstration projects, the Division may contract with health care delivery or management organizations or enter interagency service agreements with the Division of Medical Assistance or the Department of Public Health for contracts with managed health care providers to deliver services to individuals eligible for Free Care. The expenditures for such contracts shall not exceed 5,000,000 dollars annually in FY 1998 through FY 2002.

1. For Fiscal Years 1998 through 2002, payments for demonstration projects will include the EcuCare Project in North Adams and the Hampshire Health Access Project in Hampton to link uninsured and underinsured individuals and families with health care providers willing to treat such persons at reduced or no costs, in amounts determined by the general court
2. For Fiscal Years 1998 to 2002, inclusive, the Division shall allocate $2,000,000 annually for a Massachusetts Fisherman's Partnership, Inc. Demonstration project.

(e) For FY 1997, supplemental funding shall consist of $15 million transferred from Compliance Liability revenue and shall include amounts used to meet the provisions of 114.6 CMR 11.04(9)c. For FY 1998, supplemental funding shall consist of $4 million transferred from Compliance Liability revenues. For FY 2000, supplemental funding shall consist of $15 million transferred from Compliance Liability revenue. For FY 2001, supplemental funding shall consist of $1.1 million transferred from Compliance Liability revenue.

(2) Gross Liability to the Pool. A Hospital's gross liability to the Uncompensated Care pool is the product of:

(a) the ratio of its Private Sector Charges to all Hospitals' Private Sector Charges; and

(b) total Hospital liability to the Uncompensated Care pool as determined by the General Court for each Fiscal Year.

(3) Gross Liability to Hospitals. The Uncompensated Care Pool's gross liability to a Hospital is determined by the following calculation:

	Total Free Care Charges (a)
X	Cost to Charge Ratio (b)
=	Allowable Free Care Costs (c)
-	Shortfall Allocation Amount (d)
=	Pool Liability to Hospitals (e)

(a) Hospital Free Care Charges are based on the Uncompensated Care Charges filed with the Division in accordance with 114.6 CMR 11.03.

(b) The Cost to Charge Ratio is calculated in accordance with 114.6 CMR 11.04(4).

(c) Allowable Free Care Costs are the product of total Free Care Charges and the Cost to Charge Ratio.

(d) The Shortfall Amount to be allocated is calculated in the following manner:

1. determine the ratio of a Hospital's total patient care costs to the sum of all Hospitals patient care costs;
2. multiply the ratio in 114.6 CMR 11.04(3)(a) by the Shortfall Amount;
3. If the calculated amount in 114.6 CMR 11.04(3)(a)2. is greater than a Hospital's Allowable Free Care Costs, then the shortfall allocation will be limited to a Hospital's Allowable Free Care Costs.

(e) The Pool's gross liability to each Hospital is equal to the Hospital's Allowable Free Care Costs less the shortfall allocation amount.

(4) Calculation of the Cost to Charge Ratio. The Division shall calculate for each Hospital a Cost to Charge Ratio used to determine the Pool's liability to the Hospital. The Cost to Charge Ratio is the sum of each Hospital's inpatient reasonable costs and actual outpatient costs, divided by the Hospital's Gross Patient Service Revenues.

11.04: continued

(a) Data Sources. The Division will obtain cost and charge information, including capital cost, malpractice data and organ acquisition costs, from the DHCFP-403 Report. The Division will review the DHCFP-403 Cost Report to ensure that the costs and Charges reported on the DHCFP-403 Report reconcile with those reported on audited financial statements, and are true, accurate, and complete.

For purposes of calculating case-mix indices, the Division will use the merged billing and case-mix information filed pursuant to 114.1 CMR 17.00.

(b) Timing.

1. The Division will calculate a preliminary Cost to Charge Ratio before the beginning of each Fiscal Year, utilizing data from two years prior to the rate year.
2. The Division will calculate an interim Cost to Charge Ratio midway through the Fiscal Year when year end financial data from the prior Fiscal Year becomes available.
3. The Division will calculate a final Cost to Charge Ratio after the end of the Fiscal Year when final audited financial data for the rate year becomes available.

(c) Reasonable Inpatient Costs. The Division will determine reasonable inpatient costs by summing the Hospital's reasonable comparable costs, reasonable capital cost, direct medical education cost, malpractice cost, organ acquisition cost, Hospital-based physician salaries, and adjustments for inpatient Free Care provided by physicians and undocumentable Free Care, if applicable. The calculation is as follows:

Reasonable Inpatient Costs =

Reasonable comparable costs
+ Reasonable capital expense
+ Direct medical education expense
+ Malpractice expense
+ Organ acquisition expense
+ Hospital-based physician salaries
+ Adjustment for inpatient Free Care provided by physicians, if applicable
+ Adjustment for undocumentable Free Care, if applicable

The calculation of reasonable comparable costs is set forth in 114.6 CMR 11.04(4)(c)1. The calculation of reasonable capital expense is set forth in 114.6 CMR 11.04(4)(c)2.

The adjustment for inpatient Free Care provided by physicians is set forth in 114.6 CMR 11.04(4)(c)3. The adjustment for undocumentable Free Care is set forth in 114.6 CMR 11.04(4)(c)4.

1. Reasonable Comparable Costs. The Division will use an efficiency standard to determine reasonable comparable costs. Reasonable comparable costs equal the efficiency standard for Hospitals whose inpatient costs exceed the efficiency standard described below. Reasonable costs will equal actual costs for Hospitals whose costs do not exceed the efficiency standard. Specialty Hospitals, Sole Community Hospitals, and Public Service Hospitals will not be subject to the efficiency standard. The Division will calculate the efficiency standard as follows:

a. First, the Division will determine comparable costs by subtracting non-comparable costs from total inpatient costs. Non-comparable costs are: capital, direct medical education, malpractice, organ acquisition costs, and Hospital-based physician salaries. The methodology and specific data sources used to calculate these non-comparable costs will be distributed to Hospitals.

Comparable costs = Total inpatient costs
- Capital cost
- Direct Medical education cost
- Malpractice costOrgan acquisition cost
- Hospital-based physician salaries

b. Second, the Division will determine comparable costs per discharge by dividing the comparable costs by total discharges.

$$\text{Comparable cost per discharge} = \frac{\text{total comparable costs}}{\text{total discharges}}$$

11.04: continued

c. Third, the Division will adjust the comparable cost per discharge for case mix and wage area. The case-mix index will be calculated using the AP-DRG Grouper (the New York State Grouper) and New York weights. The Grouper version used will be appropriate for the ICD-9-CM diagnosis and procedure codes of the year from which the financial data is taken. The wage area indices will be those calculated by the Health Care Financing Administration (HCFA), and will be applied only to the labor portion of costs, also as determined by the Health Care Financing Administration. In Pool FY 1999 and forward, the wage area indices will be those calculated pursuant to 114.1 CMR 36.05(2)(c).

Standardized cost per discharge = Comparable cost per discharge
/ case mix index
/ wage area index

d. Fourth, the Division will calculate the mean standardized cost per discharge for all Hospitals weighted by the number of discharges in each Hospital. Specialty Hospitals, Sole Community Hospitals, and Public Service Hospitals will be excluded from this calculation. The statewide mean standardized cost per discharge is the efficiency standard.

e. Fifth, the Division will compare each Hospital's standardized cost per discharge to the efficiency standard.

(i) For Hospitals whose own standardized cost per discharge is greater than the efficiency standard, the Division will calculate reasonable comparable costs as follows. First, the Division will adjust the efficiency standard for wage area and case-mix. The wage area index will be applied only to the labor portion of costs, as determined by the Health Care Financing Administration. Second, the Division will multiply these reasonable adjusted costs per discharge by total discharges to determine reasonable comparable costs.

Reasonable adjusted cost per discharge =
Efficiency standard
x wage area index
x case mix index

Reasonable comparable costs =
Reasonable adj. cost per discharge
x total discharges

(ii) For Hospitals whose standardized cost per discharge is less than the efficiency standard, and for Specialty Hospitals, Sole Community Hospitals and Public Service Hospitals, the Division will determine that reasonable comparable costs are equal to actual comparable costs as calculated in 114.6 CMR 11.04(4)(c)1.a..

2. Reasonable Inpatient Capital Costs. Inpatient capital costs will be held to reasonable limit. In Pool FY97 and forward, the Division will include in reasonable costs only capital costs equal to or below of the reasonable capital cost limit. The Division will determine reasonable inpatient capital costs as follows:

a. The Division will calculate inpatient capital costs per discharge by dividing total capital costs allocated to inpatient by total discharges.

b. The Division will adjust inpatient capital costs per discharge for case mix. The case-mix index will be calculated using the AP-DRG Grouper (the New York State Grouper) and New York weights. The Grouper version used will be appropriate for the ICD-9-CM diagnosis and procedure codes of the year from which the financial data is taken.